Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KIRT REPP DC
PO BOX 9973
THE WOODLANDS TX 77387

Respondent Name
FEDERAL INSURANCE CO

Carrier's Austin Representative
Box Number 17

MFDR Tracking Number
M4-13-1901-01

MFDR Date Received
MARCH 26, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the insurance carrier has failed to adjudicate the 'Request for Reconsideration' as required by current rule."

Amount in Dispute: $3,430.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor billed the CPT codes 99202, 95860, 95903 and 95904 for the date of service 3/26/12. Codes 99202 and 95860 were paid. However, 95903 and 95904 were denied based on the CMS guidelines as set forth in correct coding initiatives (CCI) edits. Per the attached explanation from Corvel, CPT codes 95903 and 95904 when billed in conjunction with 95860 are not subject to reimbursement. Therefore, the denial of 95903 and 95904 was appropriate."

Response Submitted By: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 26, 2012	CPT Code 95903 (X4)	$295.00/each	$0.00
	CPT Code 95904 (X10)	$225.00/each	$0.00
TOTAL		$3,430.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 97-Charge included in another charge or service.
- R89-CCI: Misuse of Column 2 code with Column 1 code.

Issues

Does an unbundling issue exist?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason codes "97 and R89."

On the disputed date of service, the requestor billed CPT codes 99202, 95860, 95903 and 95904.

Per CCI edits, effective January 1, 2012 CPT codes 95903 and 95904 are components of code 95860. As a result, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due for the specified services. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		9/27/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.